



At the Eve of Convergence?

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At the Eve of Convergence?
Social Service Provision in Denmark, Germany and the United States

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Due to severe societal, economic and political changes, of which the financial crisis counts prominently, welfare states all over the world are under stress. In our comparative analysis, we will concentrate on specific segments of welfare state activity in Denmark, Germany, and the United States. Specifically, we will investigate whether and to what extent social services and health care in these three countries are affected by current changes. With a special focus on nonprofit organizations, we will particularly address the question whether a trend towards convergence of the very different welfare state regimes of Denmark, Germany, and the United States exists.

Introduction:

The analysis of the broad picture of welfare state changes has always been on the agenda of social policy research. During the 1950s and 1960s, a strong trend towards convergence of social policy activities was widely assumed in industrialized countries (e.g. Wilensky/Lebeaux 1958). Subsequently, the convergence theory was discredited in particular by Gøsta Esping-Andersen (1990), who in his path-breaking study argued convincingly that welfare states tend to cluster into “regimes” which, based on specific ideas and ideologies are the outcome of historical developments, and therefore not prone to be changed easily. In accordance with neo-institutionalism, path-dependency developed into one of the central approaches for explaining continuity and stability of welfare state arrangement. But recently, path-dependency as well as the “regime approach” are put to the test due to increased societal heterogeneity, changing demographics, an ever more competitive environment, and increasing public debt (Holzinger/Knill, 2005; Starke et al. 2008). Against this background, welfare states might get out of their “regime container” by opting in favor of similar solutions and responses. The potential trend towards convergence might even be facilitated by the widespread use of new public management ideas and techniques for “re-inventing of government” by adopting market solutions to public problems. Hence, one might easily argue that from a functionalist perspective, welfare states confronted with similar problems and sharing comparable policy challenges might adopt similar solutions and strategies to address social problems.

But, the welfare state constitutes a very broad concept with many facets and levels of analysis. In the following, we will draw the attention to a specific segment of welfare state activity, in particular to social services. Until recently, service provision has not been a prime topic of welfare state research, which almost exclusively tended to concentrate either on macro-economic or power-related analysis of welfare state policies, with the result that changes (or persistence) in the organization and delivery of services have been overlooked. However, due to the change of gender roles, work and family patterns, social services are increasingly appreciated as constituting important elements of welfare state activity, and in some countries costs for services have come to exceed expenditures for transfers (Goul Andersen 2007: 27; Allard, 2009). Our point of reference for the comparative analysis is social service provision in Denmark, Germany and the United States.

Again, social services constitutes a contested term covering a broad variety of social policy activities that are directly related to the well-being of individuals and which by and large are based on the *uno actu* principle, according to which, social service production is the outcome of a personal interchange between the producer and the recipient of the service. Based on tradition, countries differ with respect to the range of activities covered by the term. In the US, social services generally refers to those services “rendered to individuals and families under societal auspices excluding the major independent fields of service (that is, excluding health, education, housing, and income maintenance”) (Kahn, 1979: 20). Thus, in practical terms, “social services” refers to the social care provided to deprived, neglected, or handicapped children and youth, the needy elderly, the mentally ill and developmentally disabled, and disadvantaged adults (Kramer, 1987). In Germany, the term is closely connected with caring and counseling activities. In Denmark, the term social services by convention refers to child care and family policies, elderly care, community care and services for mentally ill and disabled, and job training programs and workforce development. For the purpose of facilitating our comparative analysis, besides family services, child care and care for the elderly, we will include health care (hospitals) in our investigation of current trends and recent developments of welfare state activities in Denmark, Germany, and the U.S. The reason for selecting these four fields is at least twofold: Firstly, worldwide these areas of social policy activity enjoy a top

priority on the political agenda. Secondly, in particular health care constitutes a highly contested area in which many stakeholders and powerful business interests are involved.

The three countries look back upon very different welfare state traditions. Each of them belongs to a particular “welfare regime”, with Denmark, according to Esping-Andersen (1990), providing a textbook-example for the so-called “social-democratic”, Germany for the “corporatist” and the U.S. for the “liberal” regime type. In accordance with the regime approach, the welfare state arrangements concerning social service and health care provision differ significantly in these countries. While in the United States, public support for social services and health care have traditionally been minimal, the hallmark of the Danish welfare state has been extensive public services. Standing in-between the two extremes of the U.S. and Denmark, Germany’s corporatist regime looks back upon a long tradition of a close partnership between nonprofit organizations and the state with respect to health care and social service provision.

Against the background of the regime approach, we address the question of convergence vs. path-dependency by focusing on social service provision particularly in these three countries, and why comparing social service and health care provision in Denmark, Germany, and the U.S. constitutes a very interesting topic of comparative welfare state analysis. A large spectrum of these services in Germany – most prominently homes for disabled people and hospitals – grew out of a so-called culture of “private welfare” (Sachße 1996). In former times, the respective institutions were founded, financed and organized either by the Churches, citizens of wealthy urban communities, or ethnic communities. Financed by and large by philanthropy, they were privately run organizations and as such non-profits (NPOs). Again, “nonprofit organization” constitutes a highly contested term. For the purpose of our comparative analysis, we refer to the terminology developed within the framework of the Johns Hopkins Comparative Nonprofit Sector Project (Salamon et al 1999: 3f).¹ From a functional point of view, NPOs, active in the area of social services and health care are by and large “service organizations”. As such, they provide services either for their members or for a broader spectrum of clients by operating institutions and facilities such as kindergartens, old-age homes, counseling programs, residential care for the disabled, hospitals, and shelters. (Sachße 2004).

At the turn of the 19th century, Denmark, Germany, and the U.S., confronted with the challenges of urbanization and industrialization took very different routes with respect to the private culture of welfare and hence concerning the integration of nonprofit organizations into their developing welfare state arrangements: In Denmark, the private culture of welfare over time was replaced by public institutions; in Germany, the organizations were thoroughly integrated into the welfare state, and hence put under the auspices of the state (Zimmer et al 2009); in the U.S., however, the organizations kept to their “privateness” (at least until the 1960s) through a heavy reliance on private donations and fees and a general lack of engagement in public policy and services (Smith/Grønbjerg 2006). Therefore, particularly due to the legacy of history, in Denmark, Germany and in the U.S. the patterns of government-nonprofit relations in social service and health care provision have traditionally differed remarkably.

To varying extents, Germany, the U.S., and Denmark, , have most recently embraced norms, values and techniques of new public management, which might have a deep impact particularly on the rationale and legitimacy of social service provision. At least in Germany, privatization of social service provision has been welcomed as a solid solution for solving fiscal problems. Moreover, facilitating increased competition among providers has developed into a mode of good governance in the area of social service and health care provision at least in this country. The rationales of these very recent policy changes are closely linked to assumptions of efficiency, effectiveness, accountability and, increasingly, consumer choice. This, however, used to constitute the normative underpinning or the bedrock of the “liberal” welfare state of the U.S.

In the U.S., social service provision particularly by nonprofit organizations has recently enjoyed a top priority on the social policy agenda. Liberal and Republican governments have strongly been opting in favor of close co-operation with nonprofit social service providers funded with government contracts as a coherent strategy to address urgent social problems including low-income housing and community development, community care, child care and drug and alcohol treatment. Increasingly, government has also relied more extensively on performance contracting and competition in many social service fields. In other words: The welfare state in the U.S. has embraced important elements of the new public management such as contracting and greater accountability while at the same time working closely with the nonprofit

sector in various fields to develop additional social service programs. Thus, increasingly the US does not neatly fit into the classic “liberal” welfare regime type. Does this already serve as a strong indicator for regime convergence?

In Denmark, outsourcing and contracting out of services to private (for-profit or non-profit) actors has in principle been accepted by both social democrats and bourgeois parties and especially for-profit providers have gained a foothold in some areas such as hospitals, elderly care, and activation policies; i.e. quasi-markets have been constructed on the basis of the classic NPM argument that competition will serve the citizen because services will become better and cheaper. Free choice has also been underlined in all social service areas and has been pursued especially by the bourgeois government since 2001. The choice is more real in some areas than in others, but the important point is the change in perception of the individual from being a citizen with rights to certain services and standards to a consumer with a choice.

Our comparative research project will take a closer look at these developments, which, at least at a short sight, seem to depart significantly from the well-established clichés of social policy development in accordance with the “social-democratic”, the “corporatist” and the “liberal” welfare state approach. More specifically in the three countries, we will investigate whether there are trends towards convergence with respect to:

- a “growth to limits” of social service provision in terms of both funding and personnel employed,
- the respective welfare mix of social service providers – public, private-commercial and nonprofit,
- the financing mix with respect to the source of revenues (public, private, philanthropic),
- the regulatory structure, i.e., who is responsible for setting quality standards,
- the ideas, or more precisely frames and ideologies, social provision in the respective country is based on and hence legitimized.

With these categories - size, welfare or institutional mix, regulation, financing, and ideological underpinning - we base our considerations on well-established frames of analysis (Alber 1995; Gidron et al 1990). In particular, we refer to Jens Alber's classic article, which for the first time laid down “a framework for the comparative study of social services” (Alber 1995). Moreover, for the comparative analysis we will

draw on the results of an extensive literature review on social services and health care in Denmark, Germany, and in the U.S., and we will use available data (WHO, National Statistical Offices, statistics of umbrella organizations active in health care and social service provision) in order to highlight trends of convergence or path-dependency in the three countries.

The case studies of social service and health care provision in Denmark, Germany, and the U.S. will follow a similar pattern. Firstly, we will outline the historical development of the respective welfare state arrangement with a special focus on the embeddedness, function and role of nonprofit organizations in the selected policy fields. Secondly, whenever possible we will provide a brief statistical portrait of the welfare mix – the institutional divide between public, commercial and nonprofit providers – of each policy field and country. Finally, for each country and with a special emphasis on nonprofits, we will highlight the according to our judgment most important trends with respect to social service and health care provision. We will finalize our comparative analysis of recent welfare state developments in Denmark, Germany, and the U.S. by a discussion of our findings that addresses specifically the question of convergence vs. path-dependency in the areas of social service and health care provision in the three countries which due to the legacy of history belong to very different welfare regimes.

The Danish case

Most observers of the Danish welfare state seem to agree that in many ways the model today still meets the fundamental criteria of universalism (Greve 2004; Goul Andersen 2007a; Goul Andersen 2007b). Compared to other countries Denmark still has a comparatively high level of taxation, generous social benefits, and income equality (Greve 2004:159). With respect to the role of third sector organizations in the welfare fields this means that they have a legitimate position as a supplementary provider of social services; though within a system of public responsibility (Klausen and Selle 1996:110; Henriksen et al 2008).

Yet, if we take a closer look institutional changes have been far reaching in some areas, though this does not seem to have come at the expense of fundamental changes in outcome (Goul Andersen 2007a:37). What is important from the perspective of this article is that some of the changes imply transformations in the division of labour and reallocation of responsibilities between state, market and third sector. However, changes seem to be much more oriented towards introducing market principles and citizens' free choices

rather than using the voluntary sector as a vehicle for social protection and social provision.

In order to understand the basic institutional welfare architecture the history of the partnership between state and third sector organizations in Denmark will be dealt with briefly below; subsequently we will provide a more detailed account of the role, size and scope of the third sector within the field of social services; and finally recent challenges to the public-private partnership will be discussed.

A brief history

The public private partnership between state and non-profit organizations in Denmark dates back to the early Christian philanthropic pioneers who already in the latter half of the 19th century worked for the benefit of marginal groups. Initiatives revolved around provision of services and help to marginalized groups such as single mothers, alcoholics, orphans, homeless people etc. who became visible with the rise of industrialism, not least in the bigger cities. Initiatives to organize private poor relief for the benefit of deserving citizens were also plenty, whereas the so-called non-deserving poor were left to public poor relief. It is characteristic that in between self support via the labour market and negligible public poor relief, a vast field of private and philanthropic initiatives and organizations flourished in the era of early classic liberalism (Henriksen and Bundesen 2004:609). In this respect Danish history resembles many other European countries as well as the US.

However, from the beginning many of these philanthropic initiatives and organizations received public support from either state or local government because it was not possible, though preferred by the liberal ideology, to raise the necessary funds through private means. Around the turn of the 20th century more institutionalized forms of cooperation also began within certain niches – for example, private homes for alcoholics could be officially recognised by the state and obtain regular financial support, and within child care local authorities were obliged to pay for children who were put in private orphanages. Municipal funds for financial support also replaced private poor relief, and at the same time some of the bigger cities, often led by social democratic mayors, initiated public hospitals, homes for the elderly, and school dental clinics (Kolstrup 1996). The increasing public responsibility, however, did not at this time put an end to private initiative. Philanthropic institutions remained essential as providers of services, constituting a supply side of organizations that state and municipalities could use to implement policies (Rathgeb Smith 2006:3). The legal foundation of this public-private partnership was later written into the famous social assistance act of 1933, in which a coordinated national social policy for the first time was formulated by a social democratic government, and in which it was made possible for voluntary organizations to run, via so-called self-governing non-profit organizations [‘selvejende institutioner’], services on contract with central and local government.

With this reform, nevertheless, a new era began, in which voluntary social service organizations gradually became instruments of the state. With respect to social service provision the post war period came to be characterised by professionalization and specialization within a universalistic welfare state framework which gradually transferred responsibility to public bodies. The peak was reached with the social reform of 1976, in which local and regional municipalities were made responsible for both provision and administration of almost all social services. There was still space for voluntary organized services - especially those run by the self-governing non-profit organizations - in niches where the voluntary sector had built up expertise over many years. But increasingly they had to adopt and follow standards and procedures prescribed by public authorities.

It is in line with more general theoretical expectations (see e.g. Anheier and Salamon 2006) that the growth of the universal welfare state led to a crowding out of voluntary organized services. This, however, should not lead to the conclusion that the post war period was characterised by a general decline in voluntary welfare organizations and initiatives (Sivesind and Selle fc). In fact, many voluntary associations were formed in the period from 1960 to 1980 to put pressure on the welfare state to take responsibility for particular problems, improve treatment capacities, and stimulate research (Lorentzen 2000:14). This development was particular strong within the area of diagnosis-based health associations and organisations for disabled people, an area which had the highest organizational growth rate from 1964 to 1983 according to one survey (Anker 1995:32-34). But also in other areas a multitude of membership based organizations representing the interests of specialised problem groups were formed (Henriksen and Bundesen 2004:618).

From the mid 1980s government introduced some new initiatives which gave more priority to the third sector. A number of social development programmes were initiated by the state and many of the grants were given to local initiatives run by voluntary organizations. A National Board on Voluntary Action was also established with the aim of strengthening the dialogue between state and voluntary sector, and in 1992 the Centre for Voluntary Social Work was established to support third sector organizations. In order to encourage cooperation and the building of public-private partnerships it was laid down in the 1998 revision of the Social Service Act that local government should cooperate with and financially support voluntary social organizations (Henriksen and Bundesen 2004:620). In 2005 another major state development programme was instigated to strengthen the quality of local volunteer centres, the aim of which are to improve local volunteering infrastructure and increase the problem solution capacity of local initiatives (Henriksen 2008). Since 2001 when the bourgeois government took power a couple of governmental Green Papers have underlined the importance of voluntary organizations in combating social exclusion and

providing services to the most marginalized group, and in a recent governmental work on a so-called ‘quality reform’ for the public sector it is suggested that all municipalities should enact a ‘policy for the local voluntary sector’.

The Danish third sector

Despite the intensified focus on volunteering and voluntary organizations government-third sector relations can still be characterised as a government dominant model (Gidron et al. 1992:18). This has, in line with what one should expect from regime theories, consequences for the size, scope and composition of the third sector, although Denmark to some degree differs from the other Nordic countries.

Measured by employment, the voluntary sector within the welfare fields is relatively small compared to other European countries; As a share of total employment within the welfare fields, non-profit employment account for 13 percent (2004) in Denmark compared to for instance 19 and 20 percent in the UK and France respectively, 25 percent in Germany, and 45 percent in the Netherlands (Sivesind 2008:169). Compared to the closest Nordic neighbours, Norway and Sweden, Danish non-profit welfare employment, however, is somewhat higher – non-profit employment account for only 4 percent in Sweden and 6 percent in Norway (Sivesind and Selle fc:13).

This marked difference between the Nordic countries is due to the abovementioned historical legacy of the *self-governing non-profit organizations* operating on contracts with regional and local government. This tradition is particular strong within the educational sector and in social services – in fact these two non-profit sub-sectors account for about two-thirds of total non-profit employment in the voluntary sector (Henriksen et al. 2008:78). Within social services we find the majority of self-governing institutions in areas such as elderly homes, child care institutions, homes for mentally and physically handicapped as well as institutions and shelters for drug addicts, battered women and homeless. Within these areas non-profit organisations hold a substantial service capacity. It is estimated that there are a total of 2,250 self-governing social service institutions in Denmark (including health). As a share of the total number of social service institutions this amounts to about 25 per cent (Ibsen & Habermann 2006:102). Table 1 below summarizes the absolute number of self-governing non-profit organizations and their share of the total number of organizations within some important social service areas.

Table 1. Self-governing non-profit organizations in Danish social service provision. Total number of non-profit organizations and their share of total number of organizations within fields. 2006.

| | Number of non-profit organizations | Non-profit share of total organizations |
|--|------------------------------------|---|
| Elderly homes | 95 | 21 % |
| Day care institutions | 1604 | 23,4 % |
| Homes and shelters for battered women, homeless etc. | 56 | 56 % |
| Homes for physically and mentally handicapped | 52 | 12 % |
| Drug treatment institutions | 28 | 78 % |
| Alcohol treatment institutions (2005) | 11 | 85 % |

Sources: Statistic Denmark official statistics and special analysis. DanRIS 2006 – STOF. DanRIS 2005 – ALKOHOL.

As one can see non-profit organizations hold a dominant position within treatment of drug and alcohol addiction, an important position in relation to the most marginalized groups, a substantial proportion within child care and elderly care, and a less important position in relation to citizens with physical and mental handicaps. However, as services are regulated by the same set of rules governing public providers, differences in terms of organization, managerial principles or value base are increasingly becoming marginal (Christensen and Pallesen 2001). Few self-governing organizations would consider themselves in opposition to society (Ibsen & Habermann 2006:119), and many of them are essentially contract partners functioning as vehicles for implementation of public policies.

Though self-governing organizations constitute an important part of the non-profit welfare sector the majority of non-profit welfare organizations are *membership-based local associations* of which the total number is estimated to 5,670 (Ibsen, Boje & Frederiksen 2008:156). Most welfare associations, however, are quite small in terms of membership, and they function to a very large extent on the basis of unpaid volunteers. Furthermore, they receive a relatively small share of their income from public subsidies – in the

range from ¼ to 1/3 of total revenues. Most of their limited means come from membership fees, sales of goods and services, and support from private foundations (Ibsen 2006:61). Genuine service provision is rare among these associations. Only about 10 percent of the associations run a service on contract with local government (Ibsen, Boje & Frederiksen 2008:149). Instead their role is twofold: First, they provide various kinds of social support and organize activities to the benefit of their local members. Second, as part of a nation-wide organizational structure where local associations are linked to regional and national umbrella organizations, they play an important role as a mechanism for users and clients to voice concerns and press government to respond to unmet needs. Most welfare associations target a particular group of people – for example elderly people, mentally ill, battered women, or special diagnosis groups - whose interests they advocate.

In conclusion; though the prevailing discourse of the ‘new welfare mix’ probably have paved the way for many local partnership agreements and a stronger awareness of the voluntary sector as an important provider, we do not see any significant reallocation of responsibilities between public sector and third sector. As one commentator noted: *“The role of voluntary associations is recognized by everybody, but nobody would envisage that they could take over functions from the state; their role can be described as supplementary and highly specialized”* (Goul Andersen: 2007a:30).

Recent developments in welfare services

The portrayal of the third sector as a supplementary provider within a state dominant environment should not, however, lead to conclude that the institutional welfare arrangements in Denmark are stable. But many of the most important changes do not seem to involve or rely on the third sector. In other words, the significant changes are taking place elsewhere, though some of these might have indirect effects on the third sector. In the following we briefly comment on some important changes within sub-fields of social services.

Within *elderly care*, which is the responsibility of local municipalities, elderly people have been granted the right to choose between public and private providers of home help services. This has led to an expansion of for-profit based, mainly practical, assistance to elderly people. By 2005 private companies reached 20 per cent of the elderly people. As they mainly provided practical assistance their share of the total work hours provided to elderly people, however, was only 3 per cent (Goul Andersen 2007a:33). Traditionally there has been a large share of non-profit self-governing homes and institutions for the elderly. Their number has decreased dramatically, however, as a result of a law passed in 1987 which made

it possible for municipalities to close down homes and institutions and convert them into individual apartments which are rented by the elderly. In 2000 there were 166 non-profit homes for the elderly, a number that was reduced to 71 in 2008. However, non-profit share has remained rather stable, about 20 per cent of total number of organizations (Statistics Denmark).

Child care services are likewise a municipal obligation and also in this area there have been attempts to implement free choice of institutions. Unlike elderly care, however, private for-profit providers have only very slowly gained some foothold in child care. However, there has been a remarkable increase in the number of private providers from 19 in 2006 to 92 in 2008 (Statistics Denmark). Still, the real choice is between different public or non-profit self-governing kindergartens, within or across municipalities, or between kindergartens and registered child-minders in their private homes [‘dagpleje’]. In both cases there is a long established tradition for user charges decided by the municipality and all institutions are regulated by the same set of rules. Thus, there are no real differences in neither prize nor quality and genuine competition is probably minor (Green-Pedersen 2002:280). This is the case, though the total number of self-governing non-profit kindergartens was as high as 1463 in 2008 (equivalent to 22 per cent of total) (Statistics Denmark).

Within *health care*, which is the responsibility of the regional authorities, three developments are central. First, patients have been granted a right to choose between hospitals. Second, patients have been granted a right to treatment within a period of one month and if the public hospitals cannot meet this, patients have the right to choose a private hospital. Third, private health insurances, which are tax deductible for employers, have spread from 50.000 in 2002 to include about 1 million Danes (out of a total population of 5.5 million) in 2008 (Andreasen et al. 2009:26). These developments have increased the market share of private for-profit hospitals. The share of for-profit somatic treatment, thus, rose from 2.5 percent in 2007 to 4 per cent in 2008 (Andreasen et al. 2009:37). Despite the growing importance of for-profit provision free and universal health care has not been contested, and there has been no privatisation of financing (Goul Andersen 2007a:31). There is also a limited number of small non-profit hospitals run by patient associations which provides supplementary treatment for chronic diseases such as epilepsy, rheumatism, muscular dystrophy etc.² Their services, however, are so specialized that they do not enter into competition with neither public nor for-profit providers.

General trends and consequences for the third sector

There are at least two common traits that characterize changes across sub fields. First, free choice is

underlined in all areas and has been pursued especially by the bourgeois government since 2001. The choice is more real in some areas than in others, but the important point is the change in perception of the individual from being a citizen with rights to certain services and standards to a consumer with a choice. Second, outsourcing and contracting out of services to private (for-profit or non-profit) actors has in principle been accepted by both social democrats and bourgeois parties and especially for-profit providers have gained a foothold in some areas such as hospitals, elderly care, and activation policies;³ i.e. quasi-markets have been constructed on the basis of the classic NPM argument that competition will serve the citizen because services will become better and cheaper.

Despite these changes in the *welfare mix* towards the market there is no retrenchment in *public expenditures* for social services. On the contrary, services have been improved and in total, public consumption is estimated to have grown by 35 per cent from 1992 to 2007 (Goul-Andersen 2007a:9). Financing of welfare service therefore is still to a very large extent a public responsibility.

Regulation and delivery of social services is also still largely a public responsibility. As a result of an administrative reform in 2007, which reduced the number of municipalities from 275 to 98, local municipalities have become responsible for close to all social services except hospitals which are the responsibility of 5 regions which replaced the former 13 counties (however, without being allowed to levy taxes anymore which has reduced their possibilities of actually steering health care services). Yet, municipal social services have become subject to closer state regulation. This is due to two reasons: First, in an effort to contain expenditures (and also to support a liberal ideology that taxes should not increase) municipalities have been subject to a centrally controlled tax ceiling which means that municipalities are not allowed to raise taxes beyond a certain level. Second, state monitoring has increased by introducing citizens' rights, quality standards, control systems, evaluation procedures and so on.

Thus, Danish social services can be said to be moving in two parallel, but probably interdependent, directions. First, the implementation of *market principles* cannot be overlooked: free choice of institutions has been implemented and internal markets have been established in important fields such as hospitals, elderly care, and activation policies where for-profit providers have been allowed to flourish.⁴

Second, *state surveillance* of municipal services and local institutions has increased. The standardisation of individual needs and local service provision means that municipal (and street level) autonomy decreases (Tranvik and Selle 2005). At the same time the tax ceiling constrains local trade off decisions between tax level and service level which traditionally has been one of the hallmarks of Danish local government.

What are the consequences of these more turbulent and competitive institutional environments for the public-private partnership and more specifically for the third sector?

As for the *self-governing non-profit organizations*, it is possible that we, in specific areas where they have many years of experience and where the municipalities recently have become responsible for the provision of services but have no expertise or capacity, could see some growth. This could be the case with for instance drug treatment, homeless shelters and other specialized institutions. In areas where non-profits do not have a foothold and no tradition for provision of services, such as hospitals and practical home help to the elderly, it is more likely that for-profits will grow whereas it seems unlikely that non-profits will be able to compete. Non-profit organizations will also have to compete for clients (or customers) in a hitherto unknown degree in a situation where they will be met with the same demands as regards service standards, cost effectiveness, and quality control as public institutions. Thus, centralization can make it more difficult for non-profits to survive, because municipalities will insist on coordination and closer scrutiny which, all things equal, is more difficult with third parties. Non-profits also risk that municipalities, in order to contain costs, will terminate contracts and create their own institutions where they can control prizes and quality standards more easily. This has happened to some degree within child care services and elderly homes. Non-profits will also become financially more vulnerable because in many cases they will be paid only for the number of clients that actually receive service or treatment, instead of receiving a basic grant which formerly used to be the rule. Overall, the most likely scenario for service provision is that we will see for-profit growth and non-profit decline.

As for the *voluntary interest associations* they will probably remain essential to push on for service improvements and expansion of public responsibility. As more and more specialized problem groups become organized, at the same time as citizens' expectations to a very large degree still is directed to the public sector (Goul Andersen (2007a:37), it is difficult to imagine a decrease in this type of advocacy organization. Probably this process will be strengthened by the fact that user influence has become mandatory in the most important service areas such as elderly homes, kindergartens, and schools. This can be described as an institutionalization of a direct voice channel for the users of a certain service; a voice which can be reinforced if coordinated with organized interest representation.

The German Case

Close cooperation between nonprofit organizations and government has traditionally constituted a hallmark of the German welfare state. In the area of social services and health care, this particular partnership – the “dual system” - translated for several reasons into an ideal situation for nonprofit organizations: 1) Legally protected from private commercial competition, NPOs worked exclusively on par with public organizations in the areas of social services and health care provision. 2) Public funding was guaranteed and allocated in accordance with the needs of the respective organization, either public or nonprofit. 3) The regulatory regime was a typical example of a “corporatist” arrangement: The umbrella associations of the public and the nonprofit sector were responsible for achieving agreements via bargaining with respect to both the quality standards of the services and the level of reimbursement for its provision. 4) The “principle of subsidiarity” served as the ideological underpinning that was referred to for legitimizing the privileged position of nonprofit organizations as service providers in the two policy fields.

However, in recent years, this particular arrangement has increasingly been put into question. Also in Germany, commercialization and the introduction of market-like mechanisms in any field of welfare state activity have become increasingly popular. How does this paradigmatic change affect in particular nonprofit organizations, active in social service and health care provision constitute the key question of the “case study” on Germany. Against the background of an résumé of the history of the “dual system” with the Free Welfare Associations as its key beneficiaries, recent policy changes will be outlined and discussed.

Historical Background of the “Dual System”

The German public – nonprofit partnership in the welfare domain started in the late 19th century. In the new industrial centers, philanthropists, members of the bourgeoisie, and progressive clerics set up numerous voluntary organizations for helping the poor. Besides traditional charity institutions, run by either the Churches or foundations, these new nonprofits constituted the bedrock of a “local culture of private welfare” (Sachße 1996: 150). Simultaneously, local governments, becoming increasingly aware of the “poverty question” started to take action against the negative side effects of industrialization by establishing e.g. departments of public health or setting up programs of social work. With the goal of making urban

planning and administration more effective, already before the turn of the 19th century, German municipalities began to co-operate with the organizations of the “local culture of private welfare”, which, increasingly treated on par with municipal institutions were step by step thoroughly integrated into local social policy planning and implementation. The local level of governance, doubtlessly served as a blueprint for both: 1) the so-called German “dual system” of public and private nonprofit social service and health care provision that for a long time excluded any commercial provider; 2) the corporatist approach of social policy planning and implementation, of which the umbrella associations of the local nonprofit social service and health care providers – the German Free Welfare Associations - developed into the main stakeholders.

Already in the 1920s alongside the growth of the welfare state (Sachße 1995), the “dual system” of service provision and the corporatist approach towards social policy development were uploaded to the Federal level of government and firmly established by the support of the developing welfare bureaucracy and the umbrella associations of the nonprofit social service and health care providers. Strongly influenced by Catholic social doctrine central stakeholders of the welfare bureaucracy were in favor of an arms length approach of service provision and social policy development. Accordingly, the umbrella associations of the welfare domain, which also came into being parallel to the growth of the welfare state, increasingly became partners of the welfare bureaucracy with respect to policy development. Particularly in the area of social service and health care provision, Germany developed into a semi-sovereign state (Katzenstein 1987), in which the umbrella associations of the local nonprofit service providers – the Free Welfare Associations - were to become powerful players in the social policy domain (Strünck 2009; Zimmer et al 2009).

The Free Welfare Associations

Germany used to be a very heterogeneous society with strong societal cleavages, organized along specific social milieus, of which the “catholic”, the “protestant” and the “social-democratic milieu” counted most prominently. Voluntary nonprofit organizations constituted the organizational infrastructure of these milieus, which were vertically integrated by “umbrella associations” that again were organized along the aforementioned normative and religious cleavages and bound together by norms and values. From the very

beginning, “umbrellas” and local nonprofits agreed upon a division of labor: “Umbrellas” operating at the federal and regional level of governance have always been primarily active in policy planning, lobbying activities and corporatist bargaining procedures included; since the early years, their membership organizations at the local level have been responsible for societal integration and service delivery.

The “umbrellas” of the local nonprofit social service and health care providers – the Free Welfare Associations – came into being at the turn of the 19th century. Today, the Free Welfare Associations are the most important social service and health care providers in Germany (Boeßenecker 2005); simultaneously, they are still holding a central position within the corporatist governance arrangement of the welfare domain. There are six associations: the German Caritas Association (Caritas/catholic), the Welfare Services of the Protestant Church in Germany (Diakonie/Diaconia/protestant), the Worker’s Welfare Service (AWO/social-democratic), the Association of Non-Affiliated Charities (Parity), the German Red Cross (Red Cross), and the Central Welfare Agency of Jews in Germany (Boeßenecker 2005). With more than 1.4 million employees and about 134,000 service units, the Free Welfare Associations are holding a key-position in the market of health care and social service provision in Germany (Bundesarbeitsgemeinschaft 2004). In terms of employees, the Free Welfare Associations make up for the largest share of the German nonprofit sector (Zimmer/Priller 2006: 57).

Table. 1: Overview of the Service Capacity of the Free Welfare Associations

Quelle: Bundesarbeitsgemeinschaft 2006

The remarkable success story of the Free Welfare Associations is closely linked to the interpretation of the “principle of subsidiarity” in Germany. Based in Catholic social doctrine, the principle was originally designed to protect individual rights against any powerful intervention from the state. After the II World War, the principle was redefined in favor of the Free Welfare Associations. It became part of German social laws underlining that local governments should abstain from setting up social service facilities (kindergartens, hospitals etc.) as long as a nonprofit organization, affiliated with the Free Welfare

Associations is able to provide the service. According to the Federal Law on Social Benefits (*BSHG*) and the Children and Youth Services Act (*Kinder- und Jugendhilfegesetz, KJHG*), local governments were required to co-operate exclusively with the Free Welfare Associations, if there is a need for social service provision. The specific interpretation of the “principle of subsidiarity”, therefore, kept commercial competitors out by providing the legitimacy for the “dual system” of welfare provision in Germany. For decades, legally protected from private commercial competition, NPOs worked exclusively on par with public organizations in the areas of social services and health care provision.

Regulation and Funding

Besides their central position in the market of social service and health care provision, the Free Welfare Associations enjoyed also privileged access to the policy arena of the welfare domain (Heinze/Olk 1981). For decades, the Associations had a “strong voice” in Germany’s social policy process, since exclusively their representatives were entitled to be in close contact with the federal bureaucracy regarding legislative issues (Hammerschmidt 2005: 161). The lobbying power of the Free Welfare Associations was further strengthened by the fact that exclusively these organizations were and still are eligible to receive a lump sum (*Globalzuschuss*) - a public grant – that is earmarked for maintaining the organizations’ infrastructure. The grant is used for covering those costs, which come along with lobbying activities, public affairs management and maintaining offices at every level of governance, Brussels included. Doubtlessly, the Free Welfare Associations were in a pool position within the “corporatist” arrangement of social policy making.

But the same held true with respect to funding. During the high day of German welfare expansion, the Free Welfare Associations on par with public institutions were in a very comfortable situation financially. Up to the 1990s, Germany’s social service providers operated without any financial risk because deficits used to be leveled by government subsidies at the end of the fiscal year. From a management point of view, this resulted in a “heaven-on-earth-situation” in which financing did not constitute an issue for public and nonprofit social service providers.

Recent Changes

In particular two significant changes have been introduced since the early 1990s: Firstly, the Federal government embarked on a cost containment strategy which translates into the situation that deficits of social service and health care providers are no longer leveled by public subsidies at the end of the fiscal year. Secondly, the Federal government modified the “principle of subsidiarity” by opening up avenues for both, commercial providers and nonprofits that are not affiliated with the Free Welfare Associations (Backhaus-Maul/Olk 1994).

Depending on the field of welfare activity, there are significant differences with respect to the outcome of the widening of access to the market of social services and health care provision. Particularly in the area of health care, the “dual system” developed to the disfavor of public health care provision. It has never been introduced in the area of care for the elderly that was inaugurated by law as a new field of welfare activity in the early 1990s, and finally, it has been slightly changed in favor of nonprofit organizations other than the Free Welfare Associations in the field of children and youth policy.

The Children and Youth Services Act (*Kinder- und Jugendhilfegesetz, KJHG*) was modified in the direction of allowing nonprofits, not affiliated with the Free Welfare Associations to set up facilities for children and youngsters. By changing the law, the Federal government adjusted to a situation that was an outcome of social movement activities in the 1980s. During this decade, parents who did not go along with those institutions run by the Free Welfare Associations set up many so-called self-governed kindergardens. These nonprofit organizations, treated now on par with the Free Welfare Associations became eligible for public subsidies.

In the area of institutional and home care, particularly for the elderly, the principle of subsidiarity was never put into place. In 1995, mandatory long-term-care insurance was introduced without giving any special preference to the Free Welfare Associations. Growing demand for care services of an aging society triggered the development of a fast growing market of commercial care providers. With 58% of the organizations being for-profit, commercial providers of care services have particularly made inroads into

the market of home services (Pabst 2009: 156). Commercial providers were less successful with respect to the area of institutional care, where the Free Welfare Associations with more than 15.000 institutions are still the most important providers (Bundesarbeitsgemeinschaft 2006: 14).

In the last decades, commercial enterprises gained terrain with respect to health care provision and in particular hospitals. Since the early 1990s, the number of private for-profit hospitals has doubled. However, there is no edging out of nonprofit hospitals, which are predominately members of the Free Welfare Associations. Nonprofit hospitals were able to keep their market share of approximately 38%, whereas public, particularly municipal hospitals were sold to hospital companies. Since 1991, the number of municipal hospitals has been reduced from more than 1100 to less than 700. There is no longer a single municipal (public) hospital operating in East Germany.

Tab. XX: Development of Hospital-Ownership in Germany, 1991- 2007

| | Hospitals according to ownership | | |
|------|---|-------------------|-------------------|
| | Numbers and percentage | | |
| | Public | Nonprofit | Commercial |
| 1991 | 1110 46% | 943 39% | 358 15% |
| 2001 | 825 37% | 903 40% | 512 23% |
| 2005 | 751 35% | 818 38% | 570 26% |
| 2007 | 677 32% | 790 38% | 620 30% |

Quelle: Statistisches Bundesamt, Fachserie 12, Reihe 6.1, www.destatis.de (07.02.2009), Zimmer, 2009

The reasons why commercial service providers are on the march in Germany are twofold: 1) the leveling of the principle of subsidiarity that traditionally gave preference to nonprofits by simultaneously keeping for-profits out, 2) the complex German system of financing of social and health care services. With respect to financing, the legal form of the service provider does not matter. Reimbursements (Leistungsentgelte) for service delivery constitute the most important revenue for social service and health care organizations. Government does not regulate the amount of money allocated for a single service. Instead, the amount of money allocated as reimbursement constitutes the outcome of a bargaining process amongst those that are involved financially and as service providers in the production of the service. Accordingly, the literature refers to a triangle of financing in which by and large representatives of the insurance funds, the municipalities and the service providers or more precisely their associations are taking part (Zimmer et al 2009: 128). This highly politicized system of setting prizes for services also translates into a situation where there are regionally significant differences with respect to the amount of money allocated for specific services.

Financing of social services is further complicated by the fact that in accordance with the German Constitution (Grundgesetz), there is a divide between those duties and obligations (Pflichtaufgaben) that municipalities have to support financially and others, which they are invited to facilitate (freiwillige Aufgaben) but they not obliged to finance. Local governments have to support financially all those services, which are covered by the Federal Law on Social Benefits (*BSHG*) and the Children and Youth Services Act (*Kinder- und Jugendhilfegesetz, KJHG*). Again, by law there is no regulation with respect to the amount of money, municipalities have to allocate for the respective service. The level of the reimbursement for service production constitutes either the outcome of a bargaining process (Pflichtaufgabe) or the result of the decision of the local parliament (freiwillige Aufgabe), and hence depends on the fiscal wellbeing of the municipality.

Besides reimbursements nonprofit social service providers are eligible to receive government subsidies. Traditionally subsidies were allocated either as annual payments or grants on demand. In accordance with new public management techniques, local governments have since the 1990s increasingly changed their funding system by introducing competitive tendering and contract management. In Germany, the shift towards new public management took place in a situation of increased fiscal constraints. In some regions, most prominently in East Germany and in the traditional industrial areas of the Ruhr-region, for more than two decades municipalities are faced with bankruptcy. Subsidies of the local government, however, constitute an important source of income, particularly for those nonprofit service providers such as self-help groups, counseling centers or centers trying to foster volunteering that do not operate under the regulation of the Federal Law on Social Benefits (*BSHG*) or the Children and Youth Services Act (*Kinder- und Jugendhilfegesetz, KJHG*).

Compared to the times of the expansion of the welfare state when the principle of subsidiarity was fully in place, local governments financially in good shape and nonprofit organizations affiliated with the Free Welfare Associations not challenged by competitors, the environment of nonprofit service providers has changed dramatically in Germany.

Convergence vs. Path-dependency?

Convergence vs. path-dependency constitutes the central question and the point of departure of our comparative analysis. Against this background, the first topic to address with respect to the German case study is related to the “growth to limits” argument of recent welfare state research. Do we observe a downturn of public funding for social service and health care provision in this country? Due to the scarcity of data this question is difficult to answer. Measured in terms of percentage of GDP, the figures of the expenditures, devoted to family and health care programs indicate a light downturn trend (Starke et al 2008, Tab. 4), while financial transfers and thus cash allowances for pensions and unemployment benefits have been stable or even on the increase during the last decades. The data underline the well-known fact that the

German welfare state has been a pioneer with respect to transfer payments, however, in accordance with the breadwinner model a latecomer concerning social service provision.

The figures provided by the umbrella organization of the Free Welfare Associations reveal a slightly different picture. Despite increased competition from commercial providers, local nonprofits, affiliated with the Free Welfare Associations and active in social service and health care provision were able at least to keep their share of the market. The number of organizations operating under the umbrella of the Free Welfare Organizations is still on the increase (Bundesarbeitsgemeinschaft 2006).

With respect to the welfare mix, there are, as already outlined, significant differences between areas of social service provision. Concerning health care, the public sector and hence municipal hospitals are doubtlessly the losers of recent developments. Nonprofit social service providers were able to keep their market share in those fields of activity, in which they have always been strongly engaged, such as in institutional care. They were less successful in new areas, such as home care for the elderly that was formally established as an important and growing market by introducing a specific “care insurance” in the mid 1990s.

For sure, the German “dual system” of public and nonprofit social service and health care provision has significantly lost importance due to the modification of the “subsidiarity principle” that, being replaced by considerations of efficiency and effectiveness does no longer serve as a source of legitimacy in the welfare domain. Despite the fact that the representatives of the commercial providers are integrated into the system, there is no change with respect to the funding of social and health care service provision. The levels of reimbursement for service delivery are still the outcome of a bargaining process in which the central players of the governance arrangement are participating. But, commercial providers have by now also a “voice” in the bargaining process.

Finally, nonprofits, engaged in social service provision that is not covered by Federal legislation but constitutes a so-called non-obligatory task (*freiwillige Aufgabe*) of the municipalities, such as advisory service for debtors might be confronted with significant cuts of public subsidies due to the severe fiscal problems of local communities, which are aggravated by the effects of the current financial crisis. It has to

be mentioned that commercial providers are not at all engaged in these fields of social service activity in Germany.

Up until now, no decisive changes with respect to the regulatory structure of social service and health care provision have been inaugurated. The Free Welfare Associations, the umbrellas of the local nonprofit service providers have been able to maintain by and large their prominent position in the arena of welfare policies; they were even able to influence significantly developments at the European level of governance (Linzbach et al 2005; Zimmer et al 2009). Indeed, the Free Welfare Associations, which look back upon a remarkable history proved to be capable to adjust themselves to a significantly changed environment by primarily intensifying their traditional division of labor between the “umbrellas” and the nonprofits operating at the shop floor level. The “umbrellas” or associations sharpened their lobbying profile by getting even more involved into politics, particularly at the European level of governance; the local nonprofit service providers became more business-like by heavily engaging in management programs and cost-containment strategies. Today, at the shop-floor level and with respect to management procedures, it is hard to tell the difference between nonprofit and commercial providers in areas under study. However, this might bring back the question of legitimacy because in contrast to the commercial providers the German Free Welfare Associations still enjoy a privileged position within the governance arrangement of the welfare domain, and they are also still receiving public subsidies for financing their organizational infrastructure, their lobby offices in Berlin, Brussels and in the regional capitals of Germany included.

The US Case

In the US, nonprofit social service agencies have grown dramatically in the last 15 years. Welfare reform sharply reduced the importance of cash assistance for the poor with a concomitant increase in the value of effective community-based social services to help poor and disadvantaged citizens (Allard, 2009). The Bush administration actively supported government funding of faith and community based agencies providing social services as a strategy to address urgent social problems and the Obama

administration has pledged to continue to seek partnerships with faith-based organizations. Community service through programs such as AmeriCorps, Teach for America, YouthBuild, and City Year have received broad political support from across the political spectrum. And starting in the 1980s, the concerted push by policymakers and advocates to develop community care for the mentally ill, developmentally disabled, and aged led to the establishment of thousands of new nonprofit community agencies and programs, supported extensively with government funds.

However, the growth of nonprofit social services has also been accompanied by a complex and contradictory trends: an increase in competition among agencies, greater pressure for accountability and improved outcomes, and incentives for collaboration and partnerships among government and nonprofit service agencies. Further, nonprofits face increased vulnerability due to the economic crisis and the constraints of a decentralized federal structure. Thus, the US social service case does not fit well with classic interpretations of the US as a liberal welfare regime with a reliance on private solutions and funding for social problems. And it has adopted management practices characteristic of many countries around the world that have embraced the market oriented reforms of the New Public Management (NPM) (Hood, 1991).

The Development of Social Services in the US: A Historical Perspective

This emergent role for nonprofit social service agencies is a sharp departure from earlier eras in American history. During colonial times, churches and early nonprofit organizations including universities and hospitals were critical and often prominent components of the social structure. But the initial structure of the American state ---with its decentralization, limited resource base, and minimal federal government role in domestic policy---created powerful incentives for a distinctly local nonprofit sector with relatively little ongoing funding support from government. Thus, nonprofits in social and health policy provided services through a mix of private donations, fees, and very modest public subsidies. Many nonprofits during this period were associations and clubs rather than service providing organizations to the public.

The late 19th and early 20th century witnessed a steady expansion in nonprofit organizations engaged in providing services to the citizenry including well-known nonprofit social service agencies such as: Catholic Charities, YMCA, Lutheran Social Services, the Salvation Army, Goodwill Industries, and the Boys and Girls Clubs. Many of these agencies were overwhelmed during the Depression in the 1930s with many agencies accepting emergency relief funds. Many local nonprofits failed entirely or merged with other nonprofits. The Depression of course dramatically changed the role of the federal government in many areas of American life including income maintenance programs such as pensions, welfare, and regulation. But surprisingly, the involvement of government, notably the federal government, in the regulation and funding of nonprofit service agencies remained quite limited or temporary for two reasons: many Depression-era funding programs were temporary and quickly ended after the start of World War II; and the federal government assumed at least part of the responsibility for poor relief, freeing at least some agencies from the direct cash and in-kind support for poor people (Morris, 2004). Consequently, nonprofit agencies in the late 1940s and 1950s remained largely dependent upon private donations and fees. Some agencies such as foster care agencies also received public subsidies for specific clients and services. Overall, the restricted character of nonprofit revenue sources meant that most agencies were relatively small and lacked extensive professionalization or infrastructure (See Smith and Lipsky, 1993).

This restricted, limited character of social services also contributed to the widespread view in the 1950s and 1960s that the American welfare state was a “laggard” in comparison to European countries who provide much more extensive social welfare services (Wilensky and Lebeaux, 1965; Also, Gilbert, 1977; 1982; Howard, 2004). Yet, partly due to the work of social policy scholars at this time who called attention to the inequities and racism of American social policy, the role of the American state in funding social services started to change in the 1960s. The Kennedy and Johnson administrations initiated a wide range of social initiatives at the federal level with profound effects on social services. The new federal initiatives had four overlapping purposes: expand opportunity, stimulate citizen action, provide new services, and expand cash transfer payments (Katz, 1996, p. 266). As a result, federal funding for a diverse array of social services delivered at the local level expanded rapidly in the late 1960s and 1970s. For

instance, spending rose on a bundle of different social services including child welfare rose from \$416 million in 1960 to \$8.5 billion in 1980 (Bixby, 1999).

The sharp overall increase in federal social spending led to a rapid buildup in social services including community mental health centers, community action agencies, new child welfare agencies, drug and alcohol treatment centers, domestic violence programs, legal services for the poor, home care, emergency shelters for youth, and workforce development programs. Most of the funding for these agencies and programs was federal although the additional spending also spurred more spending by state and local government as well (Bixby, 1999).

Over time, the federal percentage of total public social service spending grew substantially, leading to marked shift away from the voluntaristic roots of the nonprofit sector characteristic of the pre-1960s period, as reflected in the declining percentage of revenue from private donations at many of the longstanding nonprofit social welfare agencies.

Despite efforts of different administrations to reduce federal funding of social services at the local level, public funding continued to rise (until the financial crisis hit in 2008). Several reasons account for the growth of public funding. First, thousands of new, primarily nonprofit human service agencies had been established since the early 1960s; these agencies were now vocal advocates of continued public funding. Second, the growth of federal spending was encouraged by advocates for the poor, disabled, and disadvantaged. Many of these advocates were also family members who were seeking more services for their relatives and children; thus, a new constituency existed for expanded services. Third, federal spending had created another important constituency for federal social service spending----state and local government officials, especially the administrators of line agencies such as Departments of Social Services. Federal spending directly supported many positions in these agencies but also supported many private nonprofit agencies on which these agencies depended for vital public services. As such, the expansion of contracting during the 1960s and 1970s had created often tight relationships between state and local agencies and nonprofit service providers in support of more funding. Fourth, the courts had slowly started to get behind expanded social services in the community especially through landmark court decisions in the

1970s pushing deinstitutionalization of state institutions for the developmentally disabled and mentally ill (Rothman and Rothman, 2005; Smith 2007).

This new configuration of political interests, as well as the rising demand for services such as community care for the disabled, encouraged nonprofit agencies and state and local government officials to seek new sources of funding including Medicaid, the program created in 1965 as the health program for the poor. Until the 1980s, Medicaid was a very limited source of funding for traditional social services such as individual and family services or residential care for foster children. But starting in the 1980s, Medicaid has become increasingly prominent as a revenue source for social services including: mental health, child welfare, home care, hospices, counseling, residential foster care, drug and alcohol treatment, and services for the mentally ill (although the extent of coverage varies depending upon the state) (Holohan and Ghosh, 2005; Holahan, Cohen, and Rousseau, 2007; Vladeck, 2003; Smith, 2008).

In addition, other new sources of federal financing spurred the expansion of job training, child care, and other social services in the aftermath of the landmark welfare reform legislation of 1996 that created Temporary Aid to Needy Families (TANF). As part of this legislation, the federal government created new funding for services and gave greater administrative discretion to state and local governments to spend the new money including much greater flexibility by local administrators to shift money from cash assistance to services. With these new requirements and funding streams, the welfare rolls and the expenditure of funds on welfare-related programs changed dramatically: the number of families and teen parents on welfare dropped and the share of AFDC/TANF dollars spent on direct cash assistance declined rapidly, from 73 percent to 44 percent between 1996 and 2001 (Ways and Means Committee, 2004, pp. 7-3, 7-4). While federal funding for income maintenance support dropped sharply, federal funding for welfare related services rose significantly (Winston and Castanada, 2007). Overall, a large percentage of this additional service funding was spent in support of services provided by nonprofit organizations including day care, welfare to work, job training, and counseling.

In addition to Medicaid and TANF-related funding, other federal programs for at-risk youth, community service, drug and alcohol treatment, prisoner re-entry, and community care also witnessed

substantial rises in funding. Although states often were given substantial discretion on specific spending decisions and the money was often channeled through state and local governments, the overall effect of the rise in federal funding for social services was fiscal centralization even as government was devolving responsibility for service decisions to the states (Steuerle and Mermin, 1997; Scarcella, Bess, Zielowski, and Geen, 2006; Winston and Castaneda, 2007).

Significantly, the growth of nonprofit social service agencies directly connects with the widespread interest in voluntarism, citizen engagement, and community services. National programs such as AmeriCorps depend heavily upon local nonprofits for the placement of young people undertaking their community service. National nonprofits such as Teach for America, City Year, and YouthBuild rely upon partnerships with government for funding and referrals. More broadly, many nonprofits such as Habitat for Humanity, local food banks, and emergency shelters rely extensively upon volunteers to help provide various types of direct and support services.

Overall, then, nonprofit social services have increased in terms of total employment as well as the number of firms. As indicated in Table 2, the total number of social services agencies increased from 63,528 in 1995 to over 100,000 in 2005. In addition, the number of outpatient treatment facilities and mental health organizations also increased significantly. The growth in nonprofit social services agencies is also reflected in the employment figures. For instance, from 1977 to 2006, total employment rose from 676,473 to over 2.6 million (Wing, Pollak, and Blackwood, 2008; U.S. Census Bureau, 2002).

Organizational and Political Challenges Facing Nonprofit Social Service Agencies

Importantly, the financial crisis has created serious budget problems for state and local government and produced major declines in the assets of private foundations and individual donors. Many nonprofit social service agencies are thus wrestling with unprecedented challenges on their revenue side, even as some costs such as insurance, wages, health benefits continue to rise. The serious revenue problems are occurring at a time of major shifts in the political, regulatory and organizational environment of nonprofit organizations, producing major changes in the role of nonprofit agencies within the delivery of public

services

First, government at all levels has instituted more stringent expectations on performance and accountability, albeit to varying extents depending upon the state and locality. For instance, government contracts with social service agencies are more performance-based. Thus, many key social service contracts including welfare to work, mental health, workforce development, and foster care are now performance based contracts whereupon agencies are reimbursed for services only if they meet specific performance targets (Behn and Kant, 1999; Forsythe, 2001). Many private funders such as the United Way and national foundations such as the Edna McConnell Clark Foundation are also tying their grants to an expectation of meeting certain agreed-upon performance targets.

A key ripple effect of this increase in performance management, broadly defined, is the “professionalization” of the administrative and programmatic infrastructure of nonprofits especially for smaller community organizations which may have roots in local voluntarism. However, greater investment in administration and programs can be a severe challenge for these community organizations given their relative undercapitalization. Also, the resources necessary to be comply with performance contracts can raise questions about mission and programmatic focus since the performance contracts may contain expectations at variance with the previous client and program emphasis of the program. To be sure, many nonprofit social service agencies continue to rely upon volunteers even with the growing emphasis on performance contracts. However, volunteers tend to be involved in support activities such as board service and fundraising or less intensive direct service roles such as soup kitchens, crisis hot-lines, tutoring for youth, and building homes.

This shift to professionalization and performance contracting can be especially consequential for social service agencies because nonprofits emerge out of a desire of a group of like-minded “community” of people to address a problem or social need such as homelessness. These individuals create a service agency that regards its mission as logically being responsive to their community of interest (Smith and Lipsky, 1993). Government, by contrast, tends to approach services and clients from the norm of equity, consistent with the need of government officials to treat groups and individuals fairly. Equity can be

interpreted in a variety of ways, but in social and health services it usually means defining need in order to allocate resources by criteria deemed to be fair --- e.g. income, geographic location, and severity of illness or need. Because of their emphasis on responsiveness, nonprofit agencies may clash with government, especially on policy matters relating to services, clients, and staff. This clash can be especially pronounced under a performance contracting regime which can leave nonprofit social service agencies little discretion on the performance targets to be met and may require the agency to shift its programmatic focus toward short-term goals and client groups at variance with their original community of interest (Smith and Lipsky, 1993).

The steady increase in regulation has prompted by government and nonprofit agencies, to varying degrees depending upon the jurisdiction, to explore ways to achieve accountability through accreditation and self-regulation. For example, the Maryland Association of Nonprofits has developed a “Standards of Excellence” to promote high standards of ethical behavior and good governance in nonprofits. And nonprofit agencies in specific service categories such as addiction services are using accreditation to help support their efforts to enhance their impact and effectiveness. Also, government and nonprofits agencies providing public services are often engaged in a long-term relationship so both parties have an incentive to work together on performance measures and overall accountability.

The increase in performance management, combined with the fiscal crisis, has also intensified the competitive pressures on nonprofit agencies, at least in some service categories. First, government has itself shifted away from the traditional contracts that were the hallmark of the initial period of widespread government contracting in the 1960s and 1970s. In this period, most nonprofit social services agencies did not really compete with other agencies for contracts. Most contracts were cost-reimbursement contracts that essentially paid agencies for their costs based upon the contract terms and budget. Reimbursement was not linked to outcomes and most agencies recovered their costs (at least as specified in the contract). Little incentive existed for agencies to compete with other agencies for contracts since contracts were unlikely to be moved from one agency to another unless egregious problems existed. Performance contracting at least offers the threat that nonprofits could lose their contracts for poor performance

(although in practice losing contracts is still relatively rare.) The net effect is to increase the uncertainty facing nonprofits on their funding levels. Nonprofit service agencies also have an incentive to compete with their fellow agencies since they could potentially grow through additional contracts.

The diversification in the form of government funding support also profoundly changes the revenues of nonprofit social service agencies and in turn their management practices. Whereas in an earlier period, government funding primarily flowed to nonprofits through block contracts for a certain levels of service, many current forms of government support are tied to the client rather than the agency including housing and child care vouchers and tax credits and tax-exempt bond funds for housing and community development (Smith, 2006).

Nonprofits also face competition from for-profit firms, although this competition tends to vary tremendously by the service category. Many traditional social services such as foster care, youth services, and emergency assistance remain dominated by nonprofits. However, for-profit firms now compete with nonprofit agencies in key service categories such as child care, home care, and community programs for the mentally ill and developmentally disabled. For-profits possess some advantages vis a vis nonprofits in the competition for government and private client funds. First, for-profit chains have access to capital and a sufficient size that allows substantial economies of scale, allowing it to operate at least some programs more efficiently. Second, many nonprofits are mission based and small and unwilling to serve certain type of clients or in certain regions, thus reducing the opportunities for them to cross-subsidize their operations through growth or a diversified client mix. Many community based nonprofits may also be very ambivalent about expansion (or lack the capacity for expansion.) For-profits typically do not have these types of mission constraints and are thus more willing to serve a diverse mix of clients including controversial clients. Third, for-profits tend to be newer entrants to the provision of some types of social services such as home care or community programs for the mentally ill. As a new entrant, they may be able to obtain substantially higher rates from government for their services than a 30 year old community based nonprofit program, since rates for specific agencies tend to be quite dependent upon the date of founding (and the negotiating skill of the chief executive). Once established, rates tend to grow

incrementally.

The mix of for-profits and nonprofits in particular social service categories varies greatly depending upon the state and locality. Some states discourage or restrict the entry of for-profits. In some states, the nonprofit provider community is so large and entrenched that for-profits are themselves discouraged from entering specific service markets. The for-profits also tend to avoid financially risky services such as serving the homeless mentally ill. Further, rates for some services may be so low that for-profits may find it difficult to make a profit; hence nonprofits that can cross-subsidize their services with private donations or earned income may have a competitive advantage. This issue of low rates is one explanation for the relative lack of for-profit services in various welfare-to-work programs that emerged in the wake of the welfare reform bill of 1996. The payments levels and the incentives to place clients in permanent employment makes it very difficult for for-profit firms to make money; further, many of the remaining clients on welfare have complicated needs that require intensive services. For-profit social services tend to dominate in more routine services such as daycare and home care where it is also possible to generate significant volume and the barriers to entry are not as high as other social services such as child protective services or low-income housing.

Greater competition in social services is also encouraged by the growing support for my client choice in the selection of a person's service provider, especially in service categories such as mental health, developmental disabilities, and chronic illness. This movement is evident in the sharp drop in institutional care in favor of more flexible and smaller community service options requiring a variety of personal social services including home care and counseling. For instance, nationwide, the number of MR/DD clients living in settings of 1-3 residents has risen from 18,304 in 1996 to 195,450 in 2006. At the same time, the number of MR/DD clients living in settings of 16 or more people dropped from 95,345 in 1996 to 64,864 in 2006 (Prouty, Lakin and Coucouvanis, 2007, p. 1). In publicly funded mental health care, community care comprised 33 percent of all public expenditures in 1981 but rose to 70 percent in 2005 (NASMHPD, 2007). Importantly, greater competition, the shift toward more diversified means of government support, and the economic crisis require nonprofit social service agencies to alter their

management to allow them to be well-positioned to manage economic risk. In this sense, nonprofit social service agencies are adopting a more corporate management style that emphasizing growth opportunities, revenue diversification, and reducing programs that may place the organization at financial risk. Growth opportunities for revenue can include new sources of earned income including client fees, new government contracts for services that the agency previously did not provide, and expanding beyond the existing service boundaries of the agency.

Risk management and the push for revenue diversification raise the important issue of commercialization. Many scholars and nonprofit leaders worry that many nonprofits are more commercial and hence more attuned to the market for their services than their charitable mission (Weisbrod, 1998; Hansmann, 1980; Eikenberry and Kluver, 2004). In this context, commercialization is typically been linked with greater reliance on user fees and various types of market activity such as the sale of services. By implication, they are also then less reliant upon volunteers and private contributions and government grants (Weisbrod, 1998). To the extent that nonprofits practice risk management including revenue diversification, they may indeed become more reliant on various sources of fee revenue rather than donative revenue. However many nonprofit social service agencies especially in community care receive most of their program service revenue from government sources such as Medicaid and SSI payments from clients. Other nonprofits such as child welfare agencies may indeed receive commercial revenue from fees paid for agency programs such as parent trainings. But this income is typically a small portion of the agency's total revenue (NCCS, 2009b).

Overall, then, nonprofit social service agencies have tended to respond opportunistically to their funding environment which is dominated by government funding. So an agency originally founded as a mental health agency may move into providing correctional services with different government contracts. Or a drug treatment agency, faced with cutbacks in its core funding, might decide to contract with a different government entity to provide education and training for DUI offenders. An agency for individuals with AIDS, faced with changes in Medicaid, might alter its mission to serve individuals with many different types of chronic illness, thus retaining their eligibility for Medicaid funding.

As a result, the most likely programmatic response to cutbacks in government funding or endowment declines is to reduce services and staff and remain mission-based but serving fewer clients with a smaller staff. Agencies practice various forms of rationing that manage the demand for their services and essentially force many individuals seeking services to wait for longer periods of time and/or receive less service. In the more serious cases of “cutback management”, some nonprofit agencies might seek a partner agency to share back office expenses or even a friendly merger with a larger more stable agency (Sosin, Smith, Hilton, and Jordan, forthcoming).

The approach of social services agencies to risk management also suggests that social enterprise activities may be limited as a revenue strategy. In general, social enterprise refers to organizations that mix nonprofit and for-profit activities (Dees, 1997; Bielefeld, 2009). Many high profile examples of social enterprises exist including the Manchester’s Craftsmen Guild, a social service agency in Pittsburgh (www.manchesterguild.org); Farestart, an agency in Seattle with a restaurant staffed by previously homeless or low-income individuals (www.farestart.org); and Share our Strength, a national nonprofit focused on addressing hunger (www.strength.org). More typically though, a nonprofit child welfare agency or food bank or homeless shelter relies upon a mix of public funding and private contributions that is increasingly uncertain. These community agency face limited opportunities for social enterprise revenue.

As part of this overall risk management strategy, many nonprofit social service agencies are restructuring their organizations with more complex and hybrids management models (Also see Skelcher, 2004). Three different types of structures illustrate this point. First, many nonprofit social services agencies (like many other nonprofits) have established 501 (c) (3) affiliated organizations whose sole purpose is fundraising for the parent organization; this new structure reflects an effort to diversify the revenue of the organization through more aggressive private fundraising.

Second, agencies may create different subsidiaries in order to manage different programs and revenue streams. For example, the Manchester Craftsman’s Guild, a social service agency based in Pittsburgh, is actually a subsidiary of Manchester Bidwell Corporation which owns two nonprofit subsidiaries as well as a Development Trust. Share our Strength, a hunger relief organizations based in

Washington, DC, has a for-profit arm called Community Wealth Ventures to provide technical assistance to other nonprofit and for-profit organizations. Low income housing organizations create separate limited for-profit partnerships as part of their Low Income Housing Tax Credit (LIHTC) deals. A major service provider for the homeless in Seattle recently absorbed another service provider subsidiary of the parent organization. These hybrid structures may in part be dictated by laws and regulations governing their funding streams (such as the LIHTC funds). However, organizational structures such as the Seattle homeless program are also a way of minimizing the potential liability of the agency to unforeseen problems after the merger is completed.

Third, many social service agencies have created advisory committees, partnerships, and support groups to help the agency raise funds and build and broaden community support. In the current environment, this effort can be especially important for smaller community organizations since many of these organizations have often had small boards and weak community support; thus advisory committees (and larger boards) can help the agency develop deeper connections to the community.

Another noticeable trend is the growth of very large nonprofit social service agencies. Many nonprofit agencies, especially longstanding agencies such as Catholic Charities have grown very large as the services they provide such as foster care, home care and home health have increased substantially in terms of their funding. Typically the geographic reach of these agencies has also increased. Newer agencies with roots in the social entrepreneurship movement such as City Year (www.cityyear.org), a community service program for youth, YouthBuild (www.youthbuild.org), a youth and community development agency, and Pioneer Human Services (PHS) have grown large through close partnerships with government, supplemented with donative income from foundations and individuals. Community Voice Mail (www.cvm.org), an agency to help the homeless obtain employment, was started in Seattle in 1991 and now has sites in 47 cities. (Many of these sites are incorporated as separate 501 (c) (3) organizations.)

This shift toward greater size and complexity reflects the changed funding and political environment of nonprofit social service agencies. Low government payment rates in programs such as Medicaid encourage nonprofits to grow because it helps them achieve greater economies of scale and

cross-subsidize their administrative costs. Many foundations are increasingly interested in leveraging their funding and enhancing their impact so they have often pushed nonprofits, with proven results to expand their reach and geographic focus (Dees, Anderson, and Wei-Skillern, 2004; Letts, Grossman and Ryan, 1999)). Two notable examples are the support for expansion of the Harlem Children's Zone (www.hcz.org), an innovative youth agency in Harlem, by the Edna McConnell Clark Foundation and the growth of YouthBuild into several cities (Guclu, Dees, and Anderson, 2004). And finally, the growth of larger nonprofit service agencies also reflects the competitive pressures from other nonprofit and for-profit agencies because bigness may confer some advantages on agencies in terms of their ability to provide services efficiently and compete successfully for government contracts and private grants and donations.

Nonprofit Social Services in the US in Comparative Perspective

In many ways, the evolving character of nonprofit social services in the US reflects the particular features of the American welfare state in the context of general trends in public management such as NPM. The American welfare state expanded in recent years through direct and indirect funding support for nonprofit social services. The federal government's funding role has become more important through direct contract funding as well as other funding programs including Medicaid, tax credits, and vouchers. Yet, the states remain very important in regulating and funding nonprofits, reflecting the federal system in the US that gives states and localities a strong role in public policy, especially in social and health policy. Indeed, many key funding programs such as Medicaid and TANF are shared federal/state programs. But, this federal system leaves nonprofits receiving funding highly vulnerable to the changes in local political and economic conditions which in turn affects state and local budgets. Indeed, this vulnerability has been heightened in recent years because of changes in federal programs which have granted greater discretion to state and local governments on the administration and funding of important social and health programs. Also, the pressure for performance management is particularly keen at the state and local level given their economic pressures, the rising demand for services, and the sharp rise in the number of nonprofit and

for-profit service providers. In this sense, the US at the state and local level has adopted many of the practices associated with NPM characteristic of other countries including Germany and Denmark.

However, other trends suggest a movement away from market-oriented, NPM-type policies at least in part. First, Congress recently passed the Serve America Act which will provide funding for thousands of new stipended volunteers through AmeriCorps and VISTA which will promote support for local nonprofits and increased networking and partnerships among local nonprofits and public agencies. Second, major coalitions and associations representing nonprofit organizations are working closely with government at all levels on issues of mutual concern, including funding and regulatory matters. Third, the economic crisis may also hasten the shift away from the “disaggregation” tendencies characteristic of the governmental reform movement of the last 15 years (See Dunleavy, et al., 2006). The increase in contracting and the proliferation of service agencies tended to promote service fragmentation and decentralization which complicates the governance of key public services such as child welfare or mental health. Even before the economic crisis, government and nonprofit leaders were experimenting with strategies to achieve greater service integration and collaboration. Fiscal pressures are in turn increasing the interest in collaboration and even consolidation in the interests of improved efficiency and program effectiveness.

Arguably, then, the US situation reflects the evolving structure of American federalism. As Alber (1995) observed in his comparative study of social services in Europe, a country’s federal structure can be determinative in shaping the development of social services. In the US, the sharp rise of federal funding in the 1960s and 1970s essentially helped transcend important funding constraints created by the federal structure in the US. The continued availability of federal funding through programs such as Medicaid has allowed an expansion of social services to varying extents depending upon the specific service and jurisdiction; as a result, private fees and donations are much less important as a percentage of agency revenue than 50 years ago. In this sense, the US no longer fits neatly into the liberal welfare state regime model proposed by Esping-Anderson (1990), at least as it pertains to social services.

Finally, the British sociologist, T. H. Marshall (1964) argued that full citizenship hinged upon the civil, political and social rights. He viewed voluntary agencies with skepticism and suggested that statutory services were more equitable and democratic than voluntary agencies. The latter did have a role in innovation but ultimately it was the responsibility of government to adopt the innovative practices pioneered by voluntary agencies. In the US, we have essentially tried to marry the equity of government with the innovation and community roots of nonprofit organizations through extensive public funding through contracts, vouchers, and tax credits. Yet, as Marshall might have noted, this current mixed public/private arrangement lacks the transparency of government and indeed the role of government in supporting the social rights of citizens using nonprofit services tends to be obscured (Smith, 1993). However, government and by extension the citizenry need to recognize that nonprofit social service agencies are now the front-line workers in American social policy and the social rights and life chances of the citizenry hinge upon adequate funding and quality services provided by these agencies. Social services have indeed expanded to include a diverse array of community based programs but access to these services remains very conditional and susceptible to cutbacks and uncertainty. Thus, the US ---while a more expansive welfare state---continues to be an uncertain welfare state. In this sense, it has yet to fully transcend the more limited welfare state of earlier eras. This next step will require a more assertive role for the federal government and greater engagement by government and nonprofit organizations in working together to address urgent social problems.

Conclusion

Our examination of social and health services in the three countries indicates convergence in the norms of delivery and to an extent the delivery mode. That is, NPM has certainly encouraged the adoption of market strategies in the respective countries including greater emphasis on competition, the greater reliance on for-profit service organizations in community care and other services, and more individual choice in the selection of service providers. Also, a decided trend toward greater regulation and oversight of service provision which in the US and Germany is evident through the wider use of performance

contracting with nonprofit and for-profit agencies. Interestingly enough, NPM appears to have encouraged relatively little privatization of previously public services indicating in part the influence of existing institutions and path-dependent models. Thus, in Denmark, nonprofit social services remained targeted and limited to a relative handful of service categories with the most social services managed and delivered by local government. In the US, direct delivery by state and local government is quite restricted; as a result, the expansion of many social services in the recent period has been through contracts with private service agencies. Germany has a long tradition of government support for nonprofit social services; the big shift is in the introduction of market logic into the government-nonprofit relationship. Significantly, convergence does not appear to have happened in the scope of social services or funding levels. Compared to Denmark and Germany, the US has more means-tested programs that limit eligibility to the most disadvantaged or poor individuals. Further tremendous inter-state variation exists in the scope of social services due to the devolved character of the service system. To be sure, public funding of services has increased and the number of social service agencies has almost doubled since 1995. Nonetheless, important services for the poor and disabled remain out of reach for many citizens since they do not meet the eligibility criteria for public funding programs. And increasingly, agencies find it difficult to provide services to non-eligible clients since they lack the private donative resources to cross-subsidize non-eligible clients. By contrast, Denmark and Germany have more extensive social service networks with a greater entitlement to services. Both countries have universal health care ---a very important issue given the growing demand for social services such as community care which combine characteristics of health and social services.

Finally, we find that the institutional logic of a welfare state regime---an important underlying assumption of the Esping-Anderson regime typology---has important and enduring effects on welfare state development. The public-private mix affects the trajectory of the welfare state and it requires fundamental and sweeping reform to fundamentally change to funding and organizational dynamics of the welfare states. The coming years will likely bring additional fiscal pressures on government budgets and services. Consequently, an important research topic will be the impact of the new market logic including greater

individual choice on the public/private mix and the scope of service funding.

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Tab. 1: Overview of the Service Capacity of the Free Welfare Associations

| Service Facilities of the Free Welfare Sector in Germany (2004) | | | | |
|--|----------------|------------------|--------------------------|--------------------------|
| | Facilities | Beds/places | Employees (full time) | Employees (part time) |
| 1. Health Care | 7.882 | 227.442 | 231.792 | 136.575 |
| 2. Children and Youth Services | 34.406 | 1.915.782 | 146.037 | 129.023 |
| 3. Family Care | 7.646 | 47.208 | 20.040 | 47.017 |
| 4. Old People's Welfare | 15.796 | 517.788 | 166.474 | 200.829 |
| 5. Handicapped People's Welfare | 14.285 | 499.390 | 133.157 | 109.673 |
| 6. Services for People in exceptional Social Situation | 7.233 | 76.249 | 15.157 | 10.882 |
| 7. Further Services | 8.047 | 240.209 | 30.375 | 21.834 |
| 8. Education and Training in the Sector of Social Services and Care | 1.542 | 95.731 | 8.218 | 7.854 |
| In total | 98.837 | 3.619.799 | 751.250 | 663.687 |
| 9. Selfhelp Groups and further Groups of Civic Engagement | 34.923 | - | 2.363 | 4.419 |
| In total (including Selfhelp) | 133.760 | 3.619.799 | 753.613 | 668.106 |

Quelle: Bundesarbeitsgemeinschaft 2006

Table 2: Change in the Number of Reporting Human Services Agencies in US by Category, 1995, 2000, 2005*

| | Reporting Public Charities | | |
|---|----------------------------|--------|---------|
| | 1995 | 2000 | 2005 |
| Human Services | 63,528 | 81,043 | 100,436 |
| Crime and legal related | 3,818 | 4,956 | 6,044 |
| Employment and job related | 3,036 | 3,511 | 3,872 |
| Food, agriculture, and nutrition | 1,923 | 2,335 | 2,982 |
| Housing and shelter | 9,855 | 13,280 | 15,882 |
| Public safety and disaster preparedness | 2,191 | 3,455 | 5,068 |
| Recreation and sports | 11,904 | 17,439 | 24,519 |
| Youth development | 4515 | 5443 | 6501 |
| Children and youth services | 5,372 | 6,219 | 7,016 |
| Family services | 3,392 | 3,988 | 4,585 |
| Residential and custodial care | 4,654 | 5,032 | 5,388 |
| Services promoting independence | 5,920 | 6,766 | 7,813 |
| Other human services | 6,948 | 8,619 | 10,766 |
| | | | |
| Health | | | |
| Treatment facilities- outpatient | 1,654 | 2,020 | 2,343 |
| Mental health | 6,990 | 7,561 | 8,496 |

* Categories are as defined by the National Taxonomy of Exempt Entities

Source: National Center for Charitable Statistics. Selected years.

Endnotes

¹ Accordingly, nonprofits are: Organizations, i.e., they haven an institutional presence and structure; private, i.e., they are institutionally separate from the state; not profit distributing, i.e., they do not return profits to their managers or to a set of "owners"; self-governing, i.e., they are fundamentally in control of their own affairs, and voluntary, i.e., membership in them is not legally required and they attract some level of voluntary contribution of time or money" (Salamon et al 1999: 3f).

² In 2009 there were 14 such hospitals (or perhaps rehabilitation centers would be a more accurate term). Besides, there were an equal number of non-profit hospices.

³ Responsibility for *activation policies* and services in relation to unemployed people has been transferred fully to municipal job centres as a consequence of a new municipal reform in 2007. From 2002 government has tried to support privatization of services and create a market by opening the field for private providers. There has been a steady rise in the market share of private providers, as of 2005 they were responsible for about one third of all insured employed. The most important of private providers is private for-profit companies, but the labour movement and institutions for further education are also central actors, so there is in fact a mix of public, for-profit, and non-profit provision in this field (Bredgaard & Larsen 2006:85,86).

⁴ To this we may add that social protection, especially pensions and health insurance, has been privatized.